Hays CISD Student Health Services

School: _____ School Phone: _____ Fax/Nurse: _____

Authorization for Medication Administration by School Personnel
2025-2026 School Year

Student Name: _____ Birth Date: _____

Student ID: _____ Grade: _____ Gender: M / F Teacher: _____

Student's Provider: _____ Phone: _____ Fax: _____

Medication Allergies: □ No Known Drug Allergies □ Allergic to: _____

Medication requested to be given at school: _____

Has the student ever taken this medication before? □ Yes □ No (All first doses of medication must be administered at home)

Parent/Guardian Authorization

I understand that all medication(s) must be in the original container, must be provided by the parent(s) or guardian(s), and all prescription medications must have a current pharmacy label. All medications must be kept in the campus clinic unless the medication is an inhaler, epinephrine delivery device, emergency seizure medication, or medication for diabetic care AND the student is cleared by both the provider and school nurse to self-carry. All narcotics/schedule medication(s) except for emergency seizure medications must be kept in the campus clinic at all times. All medication will be administered according to the Medication Policy FFAC. First doses of medication shall not be given at school. No more than a 30-day supply of medication may be kept on campus.

I authorize the provider named below to release information regarding medication(s) my student will take, to Hays CISD Student Health Services. In addition, with my provider's permission, I agree my student may self-medicate (to include inhalers, epinephrine delivery device, diabetes care) at school. I give permission for photographs to be taken of my student to be used on the medication container and log.

I request that the designated personnel of Hays CISD administer medication to my student, named above, according to written provider's instructions and for the school nurse to exchange information with the provider's office regarding medication and health related issues. I understand it is my parental responsibility to furnish an adequate supply of this medication in the original and properly labeled container. I will notify the school immediately if the health status of my student changes, we change providers, or the medication is changed or cancelled. I understand that school district personnel will protect my student by not administering the medication if this form is not complete or the prescribed medication is not provided.

Parent/Guardian Printed Name: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

Medication Order and Provider Authorization

Please be sure to provide action plans for seizures, asthma, and severe allergies

Medication Allergies: □ NKDA □ Allergic to: _____

Medication: _____ **DOSE (mg or mcg)**: _____ Route: _____

Time(s) to be administered at school: _____ Dates to be administered: _____ OR □ Entire School Year

If PRN, describe indication: _____ May repeat PRN dose after: _____

Condition for which the medication is required: _____

Special instructions or known side effects of medication: _____

Student is authorized to **SELF-CARRY** (please check):	Student is authorized to **SELF-ADMINISTER** (please check):
□ inhaler	□ inhaler
□ epinephrine delivery device	□ epinephrine delivery device
□ emergency seizure medication	□ diabetic care supplies and medication
□ diabetic supplies and medications	

I, provider listed below, verify the above medication information is accurate and needs to be administered for the student listed.

Provider Name: _____ Signature: _____ Date: _____